



Medical Necessity Review Form for Absorbent Products

All sections of this form must be completed by the prescriber and submitted with the MassHealth Prior Authorization Request. Providers should submit this form in place of the MassHealth General Prescription Form when requesting prior authorization for absorbent products. Please refer to the instructions for completing this form provided at the end of this document. Please print or type all sections.

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|--|--|--|----------------------------------|
| 1. Member's name: | | 2. Member's MassHealth ID no.: | 3. Member's DOB: |
| 4. Member's address: | | | |
| 5. Primary diagnosis: | | 6. Secondary diagnosis: | |
| 7. Signs and symptoms of incontinence <input type="checkbox"/> Stress incontinence <input type="checkbox"/> Urge incontinence <input type="checkbox"/> Mixed incontinence <input type="checkbox"/> Overflow incontinence <input type="checkbox"/> Total incontinence <input type="checkbox"/> Other (specify): _____ | | 8. Diagnostic tests (Attach results.) <input type="checkbox"/> Urinalysis <input type="checkbox"/> Urine culture and sensitivity <input type="checkbox"/> Post-void residual determination <input type="checkbox"/> Other (specify): _____ | |
| 9. Risk factors (Use attachment as needed.) <input type="checkbox"/> Impaired mobility <input type="checkbox"/> Impaired cognitive function <input type="checkbox"/> Neurological disorders (specify): _____ <input type="checkbox"/> Chronic disease (specify): _____ <input type="checkbox"/> Urological disorders (specify): _____ <input type="checkbox"/> Other (specify): _____ | | 10. Possible reversible factors <input type="checkbox"/> Symptomatic urinary tract infection <input type="checkbox"/> Environmental conditions <input type="checkbox"/> Medical conditions <input type="checkbox"/> Medications <input type="checkbox"/> Other (specify): _____ | |
| 11. Type of treatment initiated (Attach explanation.) <input type="checkbox"/> None <input type="checkbox"/> Behavioral <input type="checkbox"/> Pharmacological: _____ <input type="checkbox"/> Surgical <input type="checkbox"/> Other (specify): _____ | | 12. Expected treatment outcome (Attach explanation.) <input type="checkbox"/> Expected to improve within 3 months <input type="checkbox"/> Expected to improve within 6 months <input type="checkbox"/> Expected to improve within 9 months <input type="checkbox"/> Expected to improve within 12 months <input type="checkbox"/> Not expected to improve | |
| 13. General Information: Height: _____ inches Weight: _____ lbs. | | | |
| 14. Location where member will use item: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other (specify): _____ | | | |
| 15. Duration of need (number of months): _____ | | | 16. No. of refills: _____ |
| 17. Absorbent product(s) | | Quantity per month | Size (S, M, L, XL) |
| <input type="checkbox"/> Diapers (Check one.): | <input type="checkbox"/> child-sized <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized | _____ | _____ |
| <input type="checkbox"/> Briefs (Check one.): | <input type="checkbox"/> child-sized <input type="checkbox"/> youth-sized <input type="checkbox"/> adult-sized | _____ | _____ |
| <input type="checkbox"/> Liner/shield (Check one.): | <input type="checkbox"/> disposable <input type="checkbox"/> reusable | _____ | _____ |
| <input type="checkbox"/> Underpad (Check one.): | <input type="checkbox"/> disposable <input type="checkbox"/> reusable | _____ | _____ |
| <input type="checkbox"/> Other (specify): _____ | | _____ | _____ |
| 18. DME provider | | | |
| Company name: | | MassHealth provider no. (if available): | |
| Address: | | Telephone no. (if available): | |
| 19. Prescriber | | 20. Person completing form on behalf of prescriber | |
| Name: | | Name: | |
| Address: | | Title: | |
| Telephone no.: | | Telephone no.: | |
| MassHealth provider no. : | | Organization: | |
| Provider UPIN: | | | |

21. Attestation: I certify that the clinical information provided on this form is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may be subject to civil or criminal liability.

Prescriber attestation (signature) _____

Date (mm/dd/yy) _____

Instructions: Complete all applicable fields on the form. Print or type all sections.

| | | |
|----------------|--|---|
| Item 1 | Member's name | Enter the member's name as it appears on the MassHealth card. |
| Item 2 | Member's ID no. | Enter the member's MassHealth identification number, which appears beside the member's name on the MassHealth card. |
| Item 3 | Member's DOB | Enter the member's date of birth in month/day/year order. |
| Item 4 | Member's address | Enter the member's permanent legal address (street address, town, and zip code). |
| Item 5 | Primary diagnosis | Enter the primary diagnosis name and ICD-9-CM code that describe the incontinence signs and symptoms for which the absorbent product is being requested. |
| Item 6 | Secondary diagnosis | Enter the secondary diagnosis names and ICD-9-CM codes (up to three codes) that further describe the medical conditions associated with the primary diagnosis. Enter "N/A" if not applicable. |
| Item 7 | Signs and Symptoms of Incontinence | Place a checkmark beside the signs and symptoms of incontinence associated with the primary diagnosis. If checking "Other," specify the signs and symptoms in the space provided (for example, fecal). |
| Item 8 | Diagnostic tests | Place a checkmark beside all diagnostic tests that apply. If checking "Other," specify the name of test(s) in the space provided. Attach test results for items checked. |
| Item 9 | Risk factors | Place a checkmark beside all risk factors that may affect incontinence treatment. If checking "Other," specify the factors in the space provided. Attach clinical information for items checked. |
| Item 10 | Possible reversible factors | Place a checkmark beside all possible reversible factors that may affect incontinence treatment. If checking "Other," specify the factors in the space provided. Attach clinical information for items checked. |
| Item 11 | Type of treatment initiated | Place a checkmark beside the type(s) of treatment that have been tried to manage incontinence. If checking "Other," specify the treatment in the space provided. Attach an explanation of responsiveness to treatment for all items checked. |
| Item 12 | Expected treatment outcome | Place a checkmark beside the item that describes the member's prognosis for improvement. Attach an explanation pertinent to the item checked. |
| Item 13 | General Information | Enter the member's height in inches and weight in pounds. |
| Item 14 | Location where member will use item | Place a checkmark beside all locations where the member will use the item. If checking "Other," specify the location in the space provided. |
| Item 15 | Duration of need | Enter the total number of months that the prescriber expects the member will require use of the items requested. Specify 1 to 99 months, where 99 indicates lifetime use. |
| Item 16 | No. of refills | Enter the amount of monthly refills for this prescription. |
| Item 17 | Absorbent product(s) requested | Place a checkmark beside the absorbent product(s) being requested. If checking "Other," specify the type in the space provided. For each product, specify the quantity per month, and the size needed (S = small; M = medium; L = large; XL = extra large). |
| Item 18 | DME provider | Enter the company name and address of the provider who will supply the absorbent product(s) being requested. If available, also provide the DME provider's telephone number and MassHealth provider number. |
| Item 19 | Prescriber | Enter the physician's/clinician's name, address, and telephone number where he or she can be contacted if more information is needed. Include the prescriber's MassHealth provider number, or if the prescriber is not a MassHealth provider, enter the prescriber's unique physician identification number (UPIN). |
| Item 20 | Person completing form on behalf of prescriber | If a clinical professional other than the treating clinician (for example, home health nurse, physical therapist, or urologist) or a physician employee answers any of the items on this form, he or she must print his or her name, professional title, and name of employer (organization) where indicated. |
| Item 21 | Attestation | The prescriber must attest that the clinical information provided on the form is accurate and complete to the best of the prescriber's knowledge by signing this field. |

Note: Prior-authorization requests with incomplete medical necessity documentation may be returned for more information or denied. Please refer to the *MassHealth Guidelines for Medical Necessity Determination for Absorbent Products* for further information about submitting required clinical documentation.